MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08089

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 26 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 1 mo. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1824 Belmont Road, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: ANDERSON, James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Genevra Anderson

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 16 April 1896

8. AGE: Years	Months	Days	If less than one day
51 ~~49~~	4	~~1918~~	hrs. min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Civil Service

11. Industry or business: Navy Department

FATHER
12. Name: Joseph Anderson
13. Birthplace: Scotland, deceased

MOTHER
14. Maiden name: Charlotte Proctor
15. Birthplace: Ireland, deceased

16. Informant: Wife: Mrs. Genevra Anderson

Address: 1824 Belmont Rd., NW, Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Joseph Gawler Joseph Gawler Sons Inc.

Address: 1756 Penn. Ave., NW, Wash., D. C.

19. 9-5 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 September 19 47 at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-9- 19 47 to 9-4- 19 47 and that I last saw h im alive on 9-4- 19 47

Immediate cause of death	DURATION
METASTATIC CARCINOMA	?
Due to CARCINOMA, RECTUM	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: OBSTRUCTIVE LESION, Date of op.

Autopsy results: CA, RECTUM

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

28. SIGNATURE: F. S. O'HARE, LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed: 9-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08090

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1235 Pennsylvania Avenue, Southeast
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II ✓

3.(a) FULL NAME: ATCHISON, Julius Ignatius

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Josephine Atchison

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1 December 1901

8. AGE:	Years	Months	Days	If less than one day
	45	9	27	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Tourist Guide

11. Industry or business: Independent

FATHER
12. Name: Claude B. Atchison
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Elizabeth Gormley
15. Birthplace: Washington, D. C.

16. Informant: Wife: Mrs. Josephine Atchison
Address: 1235 Penn. Ave., SE, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10 (month) 2 (day) 47 (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Walsh Funeral Home R.G.H.

Address: 741 11th St., SE, Washington, D. C.

19. 9-29 (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 September 1947 at 7:23 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5- 1947 to 9-28- 1947 and that I last saw him alive on 9-28- 1947

Immediate cause of death: Advanced Sub-acute hepatitis & Cirrhosis — DURATION: hepatitis mos; cirrhosis indefinite

Due to:

Due to:

Other conditions: Hepato renal syndrome, pericardite with effusion, hypostatic pneumonia
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: S F Kaufman
S. F. KAUFMAN, LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-29-47

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08091

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

CERTIFICATE OF DEATH

Reg. Diat. No. 723

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County

City or town Riley ville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Bailey, Mrs. Neta B.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. R. D. Bailey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 3, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	27	..... hrs. ..... min.

9. Birthplace Riley ville, Virginia (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own home

FATHER 12. Name Ned Deavens

FATHER 13. Birthplace Riley ville, Virginia

MOTHER 14. Maiden name Mary Belle

MOTHER 15. Birthplace Riley ville, Virginia

16. Informant Washington Sanitarium & Hospital Records

Address Takoma Park

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 30, 1947 (month) (day) (year)

Cemetery or crematory L. C. Bradley Funeral Home

Location Luray, Virginia

19. Funeral director J. Arthur Walters

Address 734 Carroll St. N.W. Takoma Park D.C.

19. Oct 1 1947 (Date rec'd by registrar) Wilma D. Ball Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947 at 4:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27, 1947, to Sept. 30, 1947 and that I last saw her alive on Sept. 30, 1947

Immediate cause of death	DURATION
Pulmonary embolism	
Due to Cardio-vascular renal disease	?
Due to	
Other conditions Diabetes mellitus	?
Appendiceal abscess (Include pregnancy within 3 months of death)	1 wk.

Major findings of operations Appendiceal abscess

Date of op. 9-29-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul V. Starr, M.D. (M. D. or other)

Address Takoma Park, Md. Date signed 9-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08C92

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 9-7-47

Hospital, institution, or street address where death occurred: Suburban Hosp 8600 Old Georgetown Rd.

How long in hospital or institution? since 9-7-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Montgomery

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6021 Western Ave N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME mr William E. BARNES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
m	w	

6.(b) Name of husband or wife Ella S. Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1864

8. AGE: Years	Months	Days	If less than one day
83		9	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation commission merchant

11. Industry or business

FATHER 12. Name John Thos Barnes

13. Birthplace Md.

MOTHER 14. Maiden name Martha Tarp

15. Birthplace Md

18. Informant hosp - records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, DC.

18. Funeral director W.W. Ahern, Tallevell

Address 3619 - 14th St. N.W. Wash 10, DC

19. 9/12/47 (Date rec'd by registrar) 1947 Wm E. Gude Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12, 1947, 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7, 1947, 19..., to Sept 12 1947, 19...

and that I last saw him alive on Sept 6, 1947, 19...

Immediate cause of death	DURATION
Uremia -	
Due to Cardio. Vascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel M Beeks MD M. D. or other

Address 5713.16th St N.W. Date signed 9.12.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

08093

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 9-11-47

Hospital, Institution, or street address where death occurred: Suburban Hosp 8600 Old George

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 710 Silver Spring Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr William F. Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Jacie L. Barnes 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1863

8. AGE: Years	Months	Days	If less than one day
84	7	22	hrs. min.

9. Birthplace: Montgomery Co, Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Jim Barnes

13. Birthplace: Montgomery Co.

MOTHER — 14. Maiden name: Mary Ellen Davis

15. Birthplace: Montgomery Co.

16. Informant: CHARLES T BARNES.

Address: 710 SILVER SPRING AVE, SILVER SPRING.

17. (Burial, cremation, or removal. Which?) BURIAL Date thereof: AUG - 17 - 1947 (month) (day) (year)

Cemetery or crematory: COLESVILLE METHODIST CHURCH.

Location: COLESVILLE, MONTG. CO. MD

18. Funeral director: Warren E Pumphrey

Address: SILVER SPRING. MD.

19. (Date rec'd by registrar) 9/17/47 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 19 47 at 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 Med Exam case 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral edema Collapse	
Due to: Left lung multiple fractures of left ribs	3 days
Due to: Struck by train	
Other conditions: Fracture of pelvis	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results: Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 9-11-47

Where did injury occur? Chevy Chase (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) B & O RR.

Means of Injury: Struck by Train Injured at work? no

23. SIGNATURE: Grant J. Bronhat M.D. M. D. or other

Address: Garrett Bldg Md Date signed: 9-14-47

LL

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

from Mrs Shope

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

08094

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo 24 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 1 mo 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3941 1st Street, Southwest
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BARRETT, Alice Frances

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Mr. Otto C. Barrett
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): 23 November 1900

8. AGE:

Years	Months	Days	If less than one day
46	9	22	..... hrs. ..... min.

9. Birthplace: New York, New York (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wallace Johnston
13. Birthplace: Prince Edwards Island, Canada

MOTHER
14. Maiden name: Anna Oneal
15. Birthplace: Ireland

16. Informant: Husb: Mr. Otto C. Barrett
Address: 3941 1st St., SW, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 17 (day) 47 (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: S. H. Hines Co. per E.H.H.
Address: 2901 14th St. NW, Washington, D. C

19. 9-14-47 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 September 19 47 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-21- 19 47 to 9-14- 19 47 and that I last saw h...er alive on 9-14- 19 47

Immediate cause of death: Uremia — DURATION: 3 wks

Primary: Due to: Hypertension, Arterial, with resulting kidney damage which caused uremia, the primary cause of death. 10/29/47 a.s. — 8 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. T. FOWLER, JR., CDR MC USN (M. D. or other)
Address: USNH, Bethesda, Md. Date signed: 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C8697

92b

CERTIFICATE OF DEATH

Reg. Dist. No. 723

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mrs. Seymour's Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4915 - 16th Street N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: KRISTIANA G. BERGENDAHL

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Gustav Storm Bergendahl
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 15, 1868

8. AGE:	Years	Months	Days	If less than one day
	79			..... hrs. ..... min.

9. Birthplace: Norway (Town, county, and state)
10. Usual occupation: None - Retired
11. Industry or business:

FATHER
12. Name: ? ---------- Gulbransen
13. Birthplace: Norway

MOTHER
14. Maiden name: ?-------- Gulbransen
15. Birthplace: Norway

16. Informant: Mr. Niles T. Severin
Address: 4915-16th St. N.W., Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 1, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Chicago, Illinois
18. Funeral director: Martin W. Hysong Co.
Address: 1300-N Street N.W., Wash. D.C.

19. Sept 29 1947 (Date rec'd by registrar) J. Wm. Dell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 29, 1947 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/14/47 1947, to 9/29/47 1947 and that I last saw her alive on 9/29/47 1947

Immediate cause of death	DURATION
Heart failure	24 hrs.
Due to: Organic heart disease with decompensation, senile.	4 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation performed.
Antopsy results: Aeterosclerosis, cerebral and Generalized - Mitral Stenosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Natural causes. Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Rowland H. Ford M. D.
Address: 52[illegible] 14th St. N.W. D.C. Date signed: 9/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

08095

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 South Courthouse Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BERTRAM, Emma L.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 March 1871

8. AGE: Years	Months	Days	If less than one day
76	6	5	hrs. min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Lt. Donald Bertram
Address: 106 S. Courthouse Rd., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 9 (day) 47 (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. L.A.A.

Address: 3072 M St., NW, Washington, D.C.

19. 9-6 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 September 19 47, at 1:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-25- 19 47, to 9-6- 19 47 and that I last saw h er alive on 9-6- 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. T. Fowler Jr
J. T. FOWLER, CDR MC USN
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

9/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08096

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
4534 Middelton Lane,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4534 Middelton Lane,
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Charles J. Bock

3. (b) Social Security Number 578-34-1838

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Julia Howell
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) February 27, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	0	hrs. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual occupation Underwriting Supervisor, FHA.
11. Industry or business

FATHER
12. Name August Bock
13. Birthplace Newark, N. J.

MOTHER
14. Maiden name Louise Breidt
15. Birthplace Newark, N. J.

16. Informant Mrs. Julia Howell Bock
Address 4534 Middelton Lane, Bethesda, Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 9/29/47 (month) (day) (year)
Cemetery or crematory Fresno, California
Location California

18. Funeral director Wm Reuben Dumphrey
Address 7557 Wisconsin Ave., Bethesda, Md.

19. 9/29 1947 Wm C Volco Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 19 47 at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 med. Exam 19 to 19 and that I last saw h alive on Exam Card 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

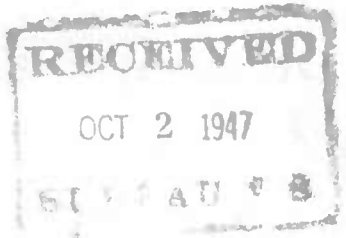
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Dep Med Exam M. D. or other
Address Gaithersburg Md. Date signed 9-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
OCT 2 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8128 08098

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Res. Forest Glen
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harriett Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	C	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1867

8. AGE: Years: 80 | Months: 6 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Rockville, Maryland.
(Town, county, and state)

10. Usual occupation: House keeper.

11. Industry or business:

FATHER
12. Name: Luther Snowden.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Jane Gordon
15. Birthplace: Maryland.

16. Informant: Mrs. Mystle Ray (daughter)
Address: Forest Glen, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion Church Cemetery
Location: Linden, Silver Spring, Md.

18. Funeral director: R. L. Snowden
Address: 246 N. Wash. St, Rockville, Md.

19. Sept 24 1947 Josephine M. Schaeffer
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 1947, at 10:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1946 to Sept 21 1947 and that I last saw h. alive on Sept 18, 1947

Immediate cause of death	DURATION
Cerebral Sclerosis	
Senile & Cerebral anoxia	
Due to Arteriosclerosis	
Cerebral & Cardiac	
Right extremity Palsy	
& Extrasystole	
Other conditions Carcinoma Urethrae	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Webster Sewell, M.D.
M. D. or other
Address: Norbeck, Md. Date signed: 9-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08099

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 211

M

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Damascus, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Damas cus MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Arthur Randolph Burns

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie L Burns
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 2.1876

8. AGE: Years	Months	Days	If less than one day
71	5	10	..... hrs. ..... min.

9. Birthplace: Montgomery County MD.
(Town, county, and state)
10. Usual occupation: Damascus, Maryland.
11. Industry or business: Merchant Paint Store

FATHER
12. Name: Richard Burns
13. Birthplace: Montgomery, County. MD.

MOTHER
14. Maiden name: Emily Watkins
15. Birthplace: Montgomery, County MD.

16. Informant: Hattie L. Burns
Address: Damascus, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept.15.1947 (month) (day) (year)
Cemetery or crematory: Damascus, Maryland.
Location: Montgomery, County MD.
18. Funeral director: Roy W. Barber
Address: Laytonsville, MD.

19. Sept. 14 19 47 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1947 5:30 PM at

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 10, 1947 to September 13, 1947
and that I last saw him alive on September 12, 1947

Immediate cause of death: Arteriosclerotic cardio vascular disease — Due to: 10 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Kerr M.D.
Address: Damascus, Md. M. D. or other
Date signed: 9/14/47

08103

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161C

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5715 Glenwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CONDON, John Anson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 18 September 1947

8. AGE: Years	Months	Days	If less than one day
		2	..... hrs. ..... min.

9. Birthplace: Bethesda, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Pomeroy Condon
13. Birthplace: Hancock, Michigan

MOTHER
14. Maiden name: Jane Anson
15. Birthplace: Pensacola, Florida

16. Informant: Father: Mr. John P. Condon
Address: 5715 Glenwood Rd., Bethesda, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9 24 47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. Rm J.

Address: 3072 M St., NW, Washington, D. C.

19. 9-21 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 September 19 47 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-18- 19 47 to 9-20- 19 47 and that I last saw him alive on 9-20- 19 47

Immediate cause of death	DURATION
Erythroblastosis fetalis	2 da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: Confirmed above diagnosis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

SIGNATURE: Paul Peterson
PAUL PETERSON, CAPT MC USN

Address: USNH, Bethesda, Maryland M. D. or other

Date signed: 9-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08100

159

S

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rual)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1616 W Street, Southeast
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CONOLEY, Elizabeth (nmi)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12 September 1947

8. AGE: Years	Months	Days	If less than one day
			hrs. 10 min.

9. Birthplace: Bethesda, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Ralph Manson Conoley
13. Birthplace: Unknown

MOTHER
14. Maiden name: Helen Doggett
15. Birthplace: Oklahoma

16. Informant: Mo: Mrs. Helen D. Conoley
Address: 1616 W St., SE, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9 (month) 16 (day) 47 (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. L.G.

Address: 517 11th St., SE, Wash., D. C.

19. 9-16 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 September 1947, at 7:28 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-12- 1947 to 9-12- 1947 and that I last saw her alive on 9-12- 1947

Immediate cause of death	DURATION
Multiple congenital anomolies	
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. A. CALLAGAN, LT MC USN
M. D., or other

Address: USNH, Bethesda, Md. Date signed: 9-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08101

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs.

Hospital, institution, or street address where death occurred:
370 Freeman Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 370 Freeman Place,
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: MARY ANDERSON CONSTANT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert E. Constant deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1861

8. AGE: Years	Months	Days	If less than one day
86	0	26	..... hrs. ..... min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Retired Gov.

11. Industry or business

FATHER
12. Name: Benjamin Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan Hughs
15. Birthplace: Maryland

16. Informant: Miss Nellie Shafor
Address: 1419 Clifton St. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/47 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Washington, D. C.

18. Funeral director: Wm Reuben Dunphrey
Address: Bethesda, Maryland

19. 9/5/47 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/5/47 19..... at 3:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/24/46 19.. to 9/5/47 19..

and that I last saw h[illegible] alive on 9/5/47 19..

Immediate cause of death	DURATION
Myocardial degeneration	1 yr.
Due to Arteriosclerosis Generalized	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel Allen MD
M. D. or other

Address: Kensington, Md. Date signed 9/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08102

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Monty
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
908 Goldsboro Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty
City or town Rockville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (Scotland)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henrietta Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 25 1877

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business

FATHER
12. Name Peter Groom
13. Birthplace md.

MOTHER
14. Maiden name Henrietta Jenkins
15. Birthplace md.

16. Informant Emma Cooper
Address Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)
Cemetery or crematory #10 Cemetery
Location Colony Johns, Md
18. Funeral director Robert L. Snowden
Address Rockville, Md.

19. 9/15 1947 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 1947, to ..... 19....
and that I last saw h... alive on Sept. 12 1947

Immediate cause of death	DURATION
Coronary occlusion	4 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Frank J. Brochat M.D. Coroner's Asst. Exam. M. D. or other
Address Gaithersburg Md. Date signed 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a+

08104

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, institution, or street address where death occurred:
Washington San. + Hospital

How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: WICOMICO

City or town: SALISBURY
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Laura Virginia Coston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe.	White	Widowed

6.(b) Name of husband or wife: W. Brice Coston

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1870

8. AGE:

Years	Months	Days	If less than one day
77	6	28	8 hrs. 30 min.

9. Birthplace: Kingston, Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Thomas H. Tull
13. Birthplace: Kingston, Md.

MOTHER
14. Maiden name: Laura B. Adams
15. Birthplace: Kingston, Md.

16. Informant: Mrs. Ward Quark

Address: 105 Williams St. Salisbury, Md.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 9-15-1947 (month) (day) (year)

Cemetery or crematory: SALISBURY

Location: WICOMICO Co. MARYLAND

18. Funeral director: Barnes & Pumphrey

Address: SILVER SPRING, MD.

19. Sept 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14 1947, at 8 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1947 to Sept 14 1947 and that I last saw her alive on Sept 14 1947

Immediate cause of death	DURATION
Leukemia-Myelogenous.	One year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A. Hare M.D.
M. D. or other

Address: Takoma Park Md. Date signed: 9/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08105

1310

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo. 29 da.

Hospital, institution, or street address where death occurred:
Washington San. & Hospital

How long in hospital or institution? 4 mo. 29 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist. of Columbia County:

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 Luchenbach St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Cullen, Mrs. Anne H.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	10	1		

9. Birthplace: Michigan City, Ind.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: August Schaustan
13. Birthplace: Germany

MOTHER
14. Maiden name: Augusta Groch
15. Birthplace: Poland

16. Informant: Wash. San. & Hosp. Records
Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29, 1947 (month) (day) (year)

Cemetery or crematory: Ft Lincoln Cem

Location: Prince George County

18. Funeral director: The S.H. Kemp Co

Address: 2901 14th St. N.W. Washington D.C.

19. Sept 26 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Sept 26 1947 and that I last saw h[illegible] alive on Sept. 26 1947

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	1 yr.
Myocarditis	6 mos.
Due to Pneumonia	guess
Osteoarthritis	
Due to	
Other conditions Possible Pneumonic Thrombosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: De Witt K. Made M. D. or other

Address: Takoma Park, Md. Date signed: 9-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

08106

CERTIFICATE OF DEATH

Reg. Diat. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Scotland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Scotland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Esker Curtis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 14, 1883

8. AGE: Years 64 | Months | Days | If less than one day hrs. min.

9. Birthplace Va (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Francis Curtis

13. Birthplace Va

MOTHER 14. Maiden name Martha Ferrell

15. Birthplace Va

16. Informant Roger M. Curtis

Address Scotland, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 12, 1947 (month) (day) (year)

Cemetery or crematory Scotland

Location Scotland, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Md.

19. 9-12 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 47, at 1:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 to Sept 9 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Chronic Nephritis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis J Boschaut M.D. M. D. or other

Address Gaithersburg, Md. Date signed 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


SEP 15
RECEIVED
SEP 15 1947

08108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Mont.

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Suburban National Bank

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Takoma Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Janet D. Dawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Harry G. Dawkins

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): July 10, 1886

8. AGE:

Years	Months	Days	If less than one day
61	2	13	..... hrs. ..... min.

9. Birthplace: Laughton Essex, England (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Archibald McWilton

13. Birthplace: Scotland (?)

MOTHER

14. Maiden name: Jessie (?)

15. Birthplace: Scotland

16. Informant: Mrs. Gilbert G. Dawkins

Address: 117 Takoma Avenue, Takoma Pk. Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Sept. 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Fork of Pa. Ave. S.E., Washington D.C.

18. Funeral director: J. Archer Walters

Address: 254 Carroll St. N.W. Takoma Park D.C.

19. Sept 23 1947 (Date rec'd by registrar) J. Wm. Rollins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 19 47 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 Med. Exam. 19 to 19

and that I last saw h alive on Case 19

Immediate cause of death	DURATION
Coronary occlusion	dec'd
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Sept Med Exam M. D. or other

Address: Gaithersburg Md. Date signed: 9-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08109

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos.

Hospital, institution, or street address where death occurred: 45 Poplar Ave.

Spring Villa Convalescent Home

How long in hospital or institution? 9 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.

City or town D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1216 Owens Pl. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war No ✓

3.(a) FULL NAME Alfred Dietz

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23 1864

8. AGE: Years	Months	Days	If less than one day
83	5	5	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Retired G.P.O. Official (Printer)

11. Industry or business Printer

FATHER 12. Name William Dietz

13. Birthplace Germany

MOTHER 14. Maiden name Marie Dingler

15. Birthplace Germany

16. Informant Albert E. Dietz Jr.

Address 1216 Owens Place N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1947 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg Md.

18. Funeral director J. Frank Joy

Address 5406 Illinois Ave N.W. Washington D.C.

19. Sept 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/21/27 1919 to 9/6/47 1919

and that I last saw him alive on 9/6/47 1919

Immediate cause of death	DURATION
Congestive heart failure	1 day
Due to cardio-vascular-renal disease	3 yrs
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Fred J Bowers M.D. M. D. or other

Address 811-8-N.E. Date signed 9/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


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SEP 11 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08107

131a

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Dickerson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Rural Dickerson Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Henry Darby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widower

6.(b) Name of husband or wife: Nancy Darby

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Montgomery Co (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: John Lemuel Darby

13. Birthplace: Montgomery Co

MOTHER 14. Maiden name: Rachel Bue

15. Birthplace: Montgomery Co

16. Informant: Mrs Nancy Darby

Address: Dickerson Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/44 (month) (day) (year)

Cemetery or crematory: Montgomery

Location: Dickerson Md

18. Funeral director: Clarence E Davis

Address: Poolesville Md

19. Oct 4 44 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 19 44 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28 19 44 to Sept 30 19 44

and that I last saw h. i.m. alive on Sept 30, 19 44

	DURATION
Immediate cause of death: Uremia	Unkn
Due to: Arterio sclerotic	
Cardio Vascular renal disease	Unkn
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. Adams, M.D. M. D. or other

Address: Poolesville, Md Date signed: 10/4/44

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

08110

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Usual address where death occurred: 324 Highview Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 324 Highview Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: John H. Duggan

3.(b) Social Security Number: 396-07-7452

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Alice S.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21st. 1884

8. AGE: Years	Months	Days	If less than one day
62	11	1	hrs. min.

9. Birthplace: Toronto, Canada
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: John Duggan
13. Birthplace: Canada

MOTHER — 14. Maiden name: Emma Webb
15. Birthplace: Canada

16. Informant: Mrs. Alice S. Duggan
Address: 324 Highview Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/23/1947 (month) (day) (year)

Cemetery or crematory

Location: Zanesville, Ohio. (Muskingum Co.)

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Sept 23 1947 (Date rec'd by registrar) Josephine M. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1947, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to 1947 and that I last saw h alive on 1947

Immediate cause of death	DURATION
Asphyxia	Instant
Due to: Hanging	Instant
Due to: (Suicide)	Instant
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9-22-47

Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D.
Diff. Med. Exam M. D. or other

Address: Gaithersburg Md. Date signed 9-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 08111

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Laytonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Laytonsville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Franklin Dwyer

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Crockett Dwyer
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 6/13/1860

8. AGE:

Years	Months	Days	If less than one day
87	3	17	... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: Reuben Dwyer
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Dwyer
15. Birthplace: Md

16. Informant: Mrs Franklin Dwyer
Address: Laytonsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1947 (month) (day) (year)
Cemetery or crematory: St Paul
Location: Laytonsville Md
18. Funeral director: Roy W Barker
Address: Laytonsville Md

19. 10/4/47 (Date rec'd by registrar) 19 ... L D Kell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/30/ 1947 at 4:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/28/ 1947 to 9/30/ 1947 and that I last saw h... alive on 9/10/ 1947

Immediate cause of death: Acute Cardiac Failure — DURATION: 1 hr

Due to: Chronic Myocarditis — 3 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Date signed 9/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08112

CERTIFICATE OF DEATH

Reg. Dist. No. 7-14

1. PLACE OF DEATH:
County Montgomery
City or town KENSINGTON, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County
City or town KENSINGTON MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3400 PYERS MILL ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. MARGARET E. ELLIOTT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife EDWIN J.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17. 1863

8. AGE: Years 84 | Months | Days | If less than one day hrs. min.

9. Birthplace Iowa (Town, county, and state)
10. Usual occupation At home
11. Industry or business
12. Name of father William English
13. Birthplace of father Not known
14. Maiden name of mother Mary Flood
15. Birthplace of mother Not known.
16. Informant Mrs. Von Steiner
Address 3400 Plyers Mill Rd. Kensington Md.
17. Wyncote, Pa. Date thereof 9-11-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Doylestown, Pa.
Location
18. Funeral director Jas. Sanders Sons
Address 1756 Penn Ave NW
19. Sept 9 1947 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 8 1947 to Sept. 8 1947 and that I last saw h.er alive on Sept 8 1947

	DURATION
Immediate cause of death Cardiac failure	24 hrs
Due to marked cerebral arteriosclerosis with degeneration	?
Due to Chronic nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

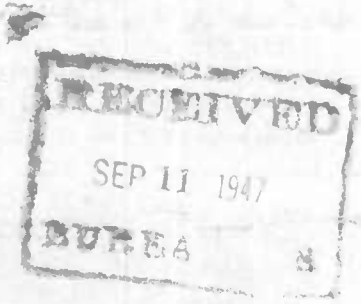
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank G. Zack M.D.
M. D. or other
Address 8248 Ga. Ave. Silver Spring Md. Date signed 9-9-47

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.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SEP 11 1947
BUREAU

08113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1448 - Girard St. N.W.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME Grace L. Fisher

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1877

8. AGE: Years	Months	Days	If less than one day
70 (?)			hrs. min.

9. Birthplace Urbana, Ohio
(Town, county, and state)

10. Usual occupation Secty

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN

16. Informant Emory H Bogley
Address 7004 - Wise Ave Ch Hts MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15-47 (month) (day) (year)

Cemetery or crematory
Location Urbana Ohio

18. Funeral director The S H Jones Co
Address 2901 - 14th St NW

19. 9/16 1947 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1947 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 19
and that I last saw h alive on 19

Immediate cause of death — DURATION
Coronary occlusion — duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brosnahan M.D.
Sept. Med. Exam
M. D. or other
Address Gaithersburg Md Date signed 9-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence signed by permission of medical examiner
for the change of year of birth & age is shown on
S. 113 10/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 08114

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred: 4803 Chevy Chase Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Montgomery County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4803 Chevy Chase Drive,
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME William Emil Frick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Edna McHaw Frick
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) October 20, 1886

8. AGE: Years	Months	Days	If less than one day
60 ~~58~~	11	5	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Construction work - Manager
11. Industry or business Construction Co.

FATHER
12. Name Adolph G. Frick
13. Birthplace Germany

MOTHER
14. Maiden name Anna Gusner
15. Birthplace Germany

16. Informant Mrs. Edna Frick
Address 4803 Chevy Chase Dr. Chevy Chase, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Maryland
18. Funeral director Wm Rawlen Trumphrey
Address 7557 Wisconsin Ave., Bethesda, Md.

19. 9/25/47 (Date rec'd by registrar) Wm E Doles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 19 47 at 2:38 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary thrombosis	30 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury Injured at work?

23. SIGNATURE George H. McLain M.D
M. D. or other
Address 1746 K. N. W. Date signed 9-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

08115

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ABOUT 1 YEAR
Hospital, institution, or street address where death occurred:
WASHINGTON SANITARIUM + HOSPITAL
How long in hospital or institution? 20 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1003 FLOWER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MRS. ADA F. FRIEDLANDER.

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED.

6.(b) Name of husband or wife: MR. BERNARD FRIEDLANDER 6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 28, 1898.

8. AGE: Years	Months	Days	If less than one day
49	7	2	....hrs. ....min.

9. Birthplace: RUSSIA (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business:

FATHER
12. Name: HYMAN WEISTOCK
13. Birthplace: RUSSIA

MOTHER
14. Maiden name: HILDA TOBYSMYOFSKY
15. Birthplace: RUSSIA

16. Informant: MRS. LILLIAN A. COHEN
Address: 3006 REISTERTOWN RD. BALTIMORE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1947 (month) (day) (year)
Cemetery or crematory: Beth Sholom [illegible] Cemetery
Location: Capitol Heights Md.

16. Funeral director: B. Wallenansky & Son
Address: 3501-14 Eastern Ave. Wash. D.C.

19. Sept 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 30, 1947 at 1 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 med. Exam only 19.... to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bosenthal M. D. Dep. Med. Examiner M. D. or other
Address: Baltimore Md. Date signed 9-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838 08116

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3017 Gates Road, Northwest
(If rural, give LOCATION)
2.(a) If veteran, name war WW I & II

3.(a) FULL NAME: FULLINWIDER, Simon Pendleton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Adelade Fullinwider
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 9 August 1897

8. AGE:

Years	Months	Days	If less than one day
50	1	10	..... hrs. ..... min.

9. Birthplace: Kansas City, Missouri (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U. S. Navy

FATHER
12. Name: Simon P. Fullinwider
13. Birthplace: Missouri

MOTHER
14. Maiden name: Betty Gaines
15. Birthplace: Missouri, deceased

16. Informant: Wife: Mrs. Adelade Fullinwider
Address: 3017 Gates Road, NW, Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9 (month) 22 (day) 47 (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: W. W. Chambers Co. P.J.K.
Address: 3072 M St., NW, Washington, D. C.

19. 9-19- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 September 19 47 at 2:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15- 19 47 to 9-19- 19 47 and that I last saw him alive on 9-19- 19 47

Immediate cause of death	DURATION
Thrombosis, right middle cerebral artery	3½ days
Due to Generalized arteriosclerosis	2 years
Due to Hypertension arterial	2 years
Other conditions Left Bundle Branch Block.	2 years
Hypostatic pneumonia	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE T. E. Jarrett, CDR MC USN M. D. or other
Address USNH, Bethesda, Md. Date signed 9-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/24/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

45 b

08117

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 2 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 3 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 461 M Street, Southwest
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: GARDNER, Malcolm Elton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Mary Gardner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11 June 1887

8. AGE: Years	Months	Days	If less than one day
60	2	28	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: John Gardner
13. Birthplace: Virginia, deceased

MOTHER
14. Maiden name: Fannie Skinner
15. Birthplace: Virginia, deceased

16. Informant: Wife: Mrs. Mary Gardner
Address: 461 M St., SW, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 12 47 (month) (day) (year)
Cemetery or crematory: Antietam National Cemetery
Location: Antietam, Maryland

18. Funeral director: W. W. Chambers Co. GB
Address: 517 11th St., SE, Washington, D. C.

19. 9-9 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 September 19 47 at 7:11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-6- 19 47 to 9-8- 19 47 and that I last saw him alive on 9-8- 19 47

	DURATION
Immediate cause of death: Respiratory failure	
Due to: Extensive carcinoma of tongue	1½ yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gale G. Clark
GALE G. CLARK, LT MC USN
M. D. or other
Address: USNH, Bethesda, Md. Date signed: 9-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

9/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

C8118

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Mt. Zion
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Mt. Zion
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Henry Gassaway Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 7, 1874

8. AGE: Years: 73 | Months: 8 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Montg. Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farmer

FATHER
12. Name: Frank Gassaway
13. Birthplace: Montgomery Co Md

MOTHER
14. Maiden name: Lucy Ann Stevenson
15. Birthplace: Montgomery Co Md

16. Informant: Henry Gassaway
Address: Olney Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1947 (month) (day) (year)
Cemetery or crematory: Oak Grove
Location: Montgomery Co Md

18. Funeral director: R. W. Barber
Address: Poolesville Md

19 10/2/47 19 ..... Louis E Bell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1947 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1946 to Sept. 30 1947 and that I last saw him alive on Sept. 29 1947

Immediate cause of death	DURATION
Chronic Nephritis	
Due to Arteriosclerosis	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Webley Sewell, M.D.
M. D. or other
Address: Norbeck Md Date signed 10.1.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

468 08119

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Montgomery — Registration Dist. No. 213

Village or City Germantown (Rural) — No. R.D.#3 Germantown — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME George Washington Genies — U. S. Veteran, specify WAR ____

(a) Residence: No. R.D.# Germantown — St. ____ — If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~ (write the word)
male	Negro	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucinda Genies

6. DATE OF BIRTH (month, day, and year): May 29th 1890

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	57	3	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Day Laborer on farm

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Farming

10. Date deceased last worked at this occupation (month and year): May 1947

11. Total time (years) spent in this occupation: 40

12. BIRTHPLACE (city or town) (State or country): Travilah — Monty Maryland (Rural)

FATHER

13. NAME: Richard Genies

14. BIRTHPLACE (city or town) (State or country): ~~Seven Locks~~ Montgomery Co Maryland

MOTHER

15. MAIDEN NAME: Susan Jackson

16. BIRTHPLACE (city or town) (State or country): Poolesville Md

17. INFORMANT (Address): Wife Lucinda Genies R.D.#3 Germantown Md

18. BURIAL, CREMATION, OR REMOVAL

Place: Seneca Md Date: Sept 21st, 1947

Tower Funeral Home

19. UNDERTAKER (Address): Robert A. Snowden Poolesville Md

20. FILED: Sept 21, 1947 — Mrs. E. L. Thompson, Registrar. By L. G. Burdette

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH September (Month) 18 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 1947, to Sept 19th, 1947

I last saw him alive on Sept 19th 1947, 19____; death is said to have occurred on the date stated above, at 7:30 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Pancreas and gall bladder	4/1/47

Other Contributory Causes of Importance: —

Name of operation: Exploratory Laparotomy — Date of: June 1947

What test confirmed diagnosis? Suspected — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury — , 19____

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. —

Manner of Injury —

Nature of Injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Upton D. Young M. D. M. D.

(Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 216

08120

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland
(b) Street address No 6 CARVER RD. CABIN JOHN MD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County MONTGOMERY
(c) City or town CABIN JOHN
(If outside city or town limits, write RURAL and give town)
(d) Street No. No 6 CARVER RD.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME CLARENCE EDWARD GIBBS JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	COLORED	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1940

8. AGE: Years	Months	Days	If less than one day
7			hr. min.

9. Birthplace WASHINGTON, D.C.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name CLARENCE E. GIBBS SR.
13. Birthplace CABIN JOHN MD.

MOTHER
14. Maiden Name LILLY MATHEWS
15. Birthplace SANDY SPRINGS MD.

16 (a) Informant LILLY GIBBS
(b) Address No 6 CARVER RD. CABIN JOHN MD.

17 (a) ~~Burial~~ Cremation (b) Date thereof 9/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory #10 Cem
Location Cabin John

18 (a) Funeral director W. Ernest Jarvis & Co
(b) Address 1432 You St. N.W.

19 (a) 9/25 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1947, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 years, to — 19..., and that I last saw him alive on June 2 1947.

Immediate cause of death Idiocy

Due to Malnutrition and dehydration

Due to Idiocy

Other Conditions ✓

(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature E. A. A. Dees M. D.
Address 4617 East West Hwy. Date signed Sept 25 1947
Bethesda, Md.

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08121

46 fx

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

8126 Georgetown Rd.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8126 Georgetown Rd.,

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: GIBSON, Arabella H.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joshua Gibson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1861

8. AGE: Years	Months	Days	If less than one day
86	6	12	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John T. Lockard

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Souder

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. John Schnell

Address: 8126 Georgetown Rd., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Maryland

18. Funeral director: Wm Reuben Humphrey

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 9/25/1947 (Date rec'd by registrar) Mrs E Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23, 1947 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to Sept 1947 and that I last saw h... alive on Sept 23 1947

Immediate cause of death	DURATION
Metastases	6 Months
Due to Cancer of Liver	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Levi Johnson M.D. M. D. or other

Address: 8126 Georgetown Rd. Date signed 9/24/47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08122

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Cabin John, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred: 5th Street,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Cabin John, Maryland (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5th Street, (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: GILL, Anna Eloise
3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife: Edward
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): August 3, 1888 ?

8. AGE: Years	Months	Days	If less than one day
59	1	14	....hrs. ....min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business:
FATHER 12. Name: Thomas E. Jones
13. Birthplace: England Whales
MOTHER 14. Maiden name: Lovey Fleming
15. Birthplace: Vermont
16. Informant: Mrs. Laura E. Linkins
Address: 5th Street, Cabin John Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof: 9/30/47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wisconsin Ave., Bethesda, Md.
19. 9/29 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27, 1947 at 11:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1947, to Sept 27 1947
and that I last saw her alive on Sept 20 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	3 hrs
Due to: Arteriosclerotic Heart Disease	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 8016 Georgetown Rd. Date signed: 9/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

476X

08123

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

9/9/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 9 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 5 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2205 K Street, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: GROSS, Walter Elberson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 20 April 1887

8. AGE: Years	Months	Days	If less than one day
60	4	14	hrs. min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: Mr. Marion Gross
13. Birthplace: Illinois

MOTHER
14. Maiden name: Mary JANE
15. Birthplace: Missouri, deceased

16. Informant: Veterans Administration Records
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof 9 (month) 4 (day) 47 (year)

Cemetery or crematory: Enid, Oklahoma

Location: Enid, Oklahoma

18. Funeral director: W. W. Chambers Co. a.p.

Address: 3072 M Street, NW, Wash., D. C.

19. 9-3 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 September 19 47, at 11:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-24- 19 47 to 9-3- 19 47 and that I last saw h im alive on 9-3- 19 47

Immediate cause of death	DURATION
Epidermoid Carcinoma of Trachea - Grade 2	6 months
Due to	
Due to	
Other conditions: Bronchopneumonia - Left bilateral, emaciation, cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

L. E. Watters

23. SIGNATURE: L. E. WATTERS, LTJG MCR USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed 9-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

08124
223

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Columbia County .....

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 N Street S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war None ✓

3.(a) FULL NAME MELVIN YOUNG HALL

3.(b) Social Security Number 577-16-0500

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife Ruth M. Hall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 19, 1891

8. AGE: Years 55 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Alexandria, Virginia
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

FATHER
12. Name Frank Hall
13. Birthplace Alexandria, Virginia

MOTHER
14. Maiden name Virginia Shook
15. Birthplace Alexandria Virginia

16. Informant Mrs. Ruth M. Hall
Address 306 N Street S.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Maryland.

18. Funeral director A. L. Gawler Funeral Home

Address 517 11th Street S.E. Wash., D.C.

19. Sept 24 1947 (Date rec'd by registrar) J. W. Hadley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1947 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1946 to Sept 24 1947 and that I last saw him alive on Sept 23 1947

	DURATION
Immediate cause of death Coronary Thrombosis	1 week
Pulmonary Infarct	unknown
Due to coronary arteriosclerosis	
Due to Hypertensive Cardiac decease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Henry J. Hadley M.D. M. D. or other

Address 1252 ... Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C8125

97

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4710 Jones Bridge Rd.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HUGH H. HAWLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Milner Hawley deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1870

8. AGE: Years	Months	Days	If less than one day
77	0	29	hrs. min.

9. Birthplace: Canada (Town, county, and state)
10. Usual occupation: Jeweler- Retired
11. Industry or business

FATHER
12. Name: John Hawley
13. Birthplace: Canada

MOTHER
14. Maiden name: Unknown
15. Birthplace: Canada

16. Informant: Mrs. George W. Wright (daughter)
Address: 4710 Jones Bridge Rd. Bethesda, Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 9/5/47 (month) (day) (year)
Cemetery or crematory: Greenville Cemetery
Location: Hunt County, Texas.

18. Funeral director: W Reuben Humphreys
Address: 7557 Wis. Ave. Bethesda, Maryland

19. 9/5 1947 (Date rec'd by registrar) M E Jones (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4, 1947 at 7:43A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-18- 1947 to 9-4 1947 and that I last saw h. alive on 9-3-47 1947

Immediate cause of death	DURATION
Pneumonia - terminal	1 day
Due to: Uremia	
Due to: Arteriosclerosis 10/22/47 AS.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul D Cantor MD (M. D. or other)
Address: 7425 Wisconsin Ave Date signed: 9-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08126

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5400 Upshur Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Handley, James C.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Elsie C. Handley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1905

8. AGE: Years	Months	Days	If less than one day
44	6		hrs. min.

9. Birthplace: Ft. Green, Florida (Town, county, and state)

10. Usual occupation: Postal Clerk

11. Industry or business: City Post Office D.C. 13

FATHER — 12. Name: George Lafayette

FATHER — 13. Birthplace: Florida

MOTHER — 14. Maiden name: Jessie Keene

MOTHER — 15. Birthplace: Florida

16. Informant: Wife Same Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 6 - 1947 (month) (day) (year)

Cemetery or crematory

Location: 3200 R.I. Ave. Mt. Rainier Md.

18. Funeral director: Wm. J. Malley

Address: 3200 R.I. Ave. Mt. Rainier Md.

19. Sept. 6 1947 (Date rec'd by registrar) J. W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1947 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1947 to Sept. 6 1947 and that I last saw h[illegible] alive on Sept. 6 1947

	DURATION
Immediate cause of death: Uremia	Hrs(?)
Due to: Kidney failure	Hrs(?)
Due to: Acute exacerbation of Chronic Emphysematous Pulmonary tuberculosis	12 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Russell A. Dunn M.D. M. D. or other

Address: Washington San. + Hosp. Date signed: Sept 6, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
SEP 11 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

08127

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington Sant Hosp.

How long in hospital or institution? 35 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Lanham

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Defense Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EDWARD A. HINES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1885

8. AGE: Years	Months	Days	If less than one day
62	—	26	..... hrs. ..... min.

9. Birthplace: Asheville, North Carolina (Town, county, and state)

10. Usual occupation: Dealer

11. Industry or business

FATHER — 12. Name: Edward Hines

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Susan Craig

MOTHER — 15. Birthplace: North Carolina

16. Informant: Son — Alphin Hines

Address: Defense Highway, Lanham, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19, 1947 (month) (day) (year)

Cemetery or crematory: Washington Natl Cemetery

Location: Suitland Rd, Md.

18. Funeral director: W W Chambers Co

Address: Funeraldale, [illegible]

19. Sept 17 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/28 1947, to Sept 16 1947 and that I last saw him alive on Sept 15 1947

Immediate cause of death	DURATION
coronary thrombosis	
Due to: coronary sclerosis	unknown
Due to: Hypertensive cardiac disease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: 1252 [illegible] Date signed: Sept 20 47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

182 S 08128

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital or institution, or street address where death occurred:
9228 Woodland drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington County: King
City or town: Seattle
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3634 W. Lawton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Frank T. Hodge

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: X
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 18th. 1947

8. AGE: Years	Months	Days	If less than one day
0	8	4	hrs. min.

9. Birthplace: Seattle, Wash.
(Town, county, and state)

10. Usual occupation: X

11. Industry or business

FATHER
12. Name: Frank E. Hodge
13. Birthplace: Detroit, Mich.

MOTHER
14. Maiden name: Margaret Thomas
15. Birthplace: Toledo, Ohio.

16. Informant: Mrs. Frank E. Hodge
Address: 9228 Woodland Dr. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/1947 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Co., Virginia.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Sept 23 1947 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1947, at 12:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept med. Exam 1947 to 1947 and that I last saw h alive on Sept 22 1947

Immediate cause of death	DURATION
Asphyxia	Instantaneous
Due to: Strangulation in tractor	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 9-22-47
Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D.
Sept med. Exam M. D. or other
Address: Gaithersburg Md. Date signed: 9-22-47

08129

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
XXXXXXXX
205 Buffalo Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 205 Buffalo Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Edward Holmes

3.(b) Social Security Number: 577-03-0442

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edith Waever

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 29th. 1883

8. AGE: Years	Months	Days	If less than one day
64	7	2	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: President

11. Industry or business: Progressive Bldg. & Loan Assn.

FATHER
12. Name: Charles Holmes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Alice Smart
15. Birthplace: Unknown

16. Informant: Mrs. Edith Weaver Holmes

Address: 205 Buffalo Ave. Takoma Pk.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 9/4/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Pr. Geo's Co. Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Sept. 3 1947 (Date rec'd by registrar) J Wilson Todd Registrar

R29

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1947, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st Med. Exam case, 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death ..... DURATION

Coronary occlusion — Instantaneous

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Sept Med. Exam M. D. or other

Address: Gaithersburg Md. Date signed 9-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08130

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Diat. No. 717

1. PLACE OF DEATH:

County: Montgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Spring Villa Conv. Home.

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 Poplar.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Henry H Hosmer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: ?

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 17, 1862

8. AGE: Years	Months	Days	If less than one day
85	1	1	..... hrs. ..... min.

9. Birthplace: Nashville Ill.

(Town, county, and state)

10. Usual occupation: Retired Lawyer.

11. Industry or business

FATHER

12. Name: P. E. Hosmer

13. Birthplace: Vermont

MOTHER

14. Maiden name: Catherine Gosney

15. Birthplace: Ohio

16. Informant: Howard Hoemer

Address: 5027 Reno Rd. Wash. DC.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Sept 18, 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location .....

18. Funeral director: The S.H. Hines Co.

Address: 2901 14th St NW. Wash. D.C.

19. Sept. 18 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1947 at 12 43 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Sept 18 1947 and that I last saw h.. alive on Sept 17 1947

Immediate cause of death	DURATION
Myocardial Failure	
Due to: Coronary Infarction	
Due to: Arteriosclerotic Heart Disease	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Glenn N. Harding MD M. D. or other

Address: 1123 Carroll St NW. Wash DC Date signed: 9-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08131

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Lincoln Park (Rockville)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 161
(If rurol, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: JACKSON, Thomas J.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 20 September 1924

8. AGE: Years	Months	Days	If less than one day
22	11	16	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: U. S. Public Health Service

FATHER
12. Name: Rubin Waters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude Jackson
15. Birthplace: Maryland

16. Informant: Mother: Mrs. Gertrude Jackson
Address: Boyds, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: St. Rose Cemetery

Location: Cloppers, Maryland

18. Funeral director: Ernest C. Gartner E.V.

Address: Gaithersburg, Maryland

19. 9-6 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

9/8/47

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 September 19 47 at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5- 19 47 to 9-5- 19 47 and that I last saw h... alive on 9-5- 19 47

Immediate cause of death	DURATION
Hemorrhage, subarachnoid,	4-5 hours
Due to (a) ruptured aneurism (congenital aneurism suspected but not found on gross exam.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Massive subarachnoid hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul R. Engle PAUL R. ENGLE, CDR MC USN M. D. or other

Address: USNH, Bethesda, Md. Date signed: 9-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 08132

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 9 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 3 mos. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1530 A Street, Northeast

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American War ✓

3.(a) FULL NAME: JARRETT Edward Alanzo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Mamie K. Jarrett

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): 25 December 1879

8. AGE: Years	Months	Days	If less than one day
67	9	1	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Civil Service

FATHER — 12. Name: Eli Jarrett

FATHER — 13. Birthplace: West Virginia, deceased

MOTHER — 14. Maiden name: Hattie Vetura

MOTHER — 15. Birthplace: West Virginia, deceased

16. Informant: Wife: Mrs. Mamie K. Jarrett

Address: 1530 A St., NE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Cedar Hill, Maryland

18. Funeral director: Lee Funeral Home Gann

Address: 4th & Mass., NE, Washington, D. C.

19. 9-27 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 September 1947 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-17- 1947 to 9-26- 1947 and that I last saw him alive on 9-26- 1947

Immediate cause of death	DURATION
CORONARY THROMBOSIS and myocardial Infarction	
Due to: Coronary arteriosclerosis	
Due to: ARTERIO- and arteriolosclerosis, generalized.	
Other conditions: Arteriolonephrosclerosis; Malignant Hypertension; cerebral atrophy; Infarct right kidney with necrosis	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: (SAME AS ABOVE)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. J. B. BRYAN, JR., LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4624

08133

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since December 1945

Hospital, institution, or street address where death occurred: 8808 Grant Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8808 Grant Street

(If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3. (a) FULL NAME: Charles Henry Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marion E. Johnson

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): December 31, 1891

8. AGE: Years	Months	Days	If less than one day
55	8	26	22 hrs. ... min.

9. Birthplace: Halifax County, Virginia (Town, county, and state)

10. Usual occupation: Farmer and carpenter

11. Industry or business: Governments employee

FATHER — 12. Name: John H. Johnson

FATHER — 13. Birthplace: Halifax County, Virginia

MOTHER — 14. Maiden name: Mary Ella Dixon

MOTHER — 15. Birthplace: Halifax County, Virginia

16. Informant: Marion E. Johnson

Address: 8808 Grant Str. Bethesda, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept 30, 1947 (month) (day) (year)

Cemetery or crematory: Halifax, Va.

Location: Dixie

18. Funeral director: J. W. Lee's Sons Co

Address: 300-4 St. NE - D.C.

19. Sept 28 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1947, at 10:0. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1947 to September 27 1947 and that I last saw h... alive on September 27 1947

Immediate cause of death: Carcinoma of the colon — DURATION: Diagnosis made July 1947 at Naval Hospital Bethesda, Md.

Due to:

Due to:

Other conditions: Duanitrin, Bowel hemorrhages

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paula E. Mahler M.D. (M. D. or other)

Address: 8712 Old Georgetown Rd. Date signed: 9/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

08134

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 8104 Rockcrest Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4701 Homes Ave S E

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Louise Rawlings Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Fred Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan, 4 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	8	20		

9. Birthplace: Spotsylvania Co. Va.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: James Rowlings

13. Birthplace: Va.

MOTHER — 14. Maiden name: Clara Boggs

15. Birthplace: Va

16. Interment: James A Johnson

Address: 4701 Homes Ave. S E

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location: Washington D C

18. Funeral director: J Will Lee & Sons

Address: 300-4th St NE

19. Sept 25 1947 (Date rec'd by registrar) Alma G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 19 47 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 47 to Sep 24 19 47 and that I last saw h[illegible] alive on Sept 23 19 47

Immediate cause of death: Chronic degenerative myocarditis — DURATION

Due to:

Due to:

Other conditions: Hypertensive

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Schwartzman M. D. or other

Address: 2015 Nichols St. Date signed: 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52 ax (Clarksburg Md

Reg. Dist. No. 218

08135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Montgomery

City or town Near Germantown (Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R 7 D#2 Boyds

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 13 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Germantown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R 7 & #2 - Boyds Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Donald. Lee. Keeney.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 11th 1923

8. AGE:

Years	Months	Days	If less than one day
21	9	12	— hrs. — min.

9. Birthplace Liberty Frederick Co. Md.
(Town, county, and state)

10. Usual occupation Helper at Home.

11. Industry or business —

FATHER
12. Name Percy Keeney
13. Birthplace Woodsboro Md

MOTHER
14. Maiden name Bessie A Smith
15. Birthplace Liberty Frederick Co Md

16. Informant Mother - Mrs Bessie A Keeney
Address R 7 & #2. Boyds Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25th 1947 (month) (day) (year)

Cemetery or crematory Rocky Hill Cemetery

Location Woodsboro Md. R. D

18. Funeral director Powell & Gaitzer

Address Liberty Town + Woodsboro Md

19. Sept 23 1947 (Date rec'd by registrar) Glenda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23rd 1947 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 19 to Sept 23rd 1947, and that I last saw h— alive on Sept 23rd 1947

	DURATION
Immediate cause of death Carcinoma of Kidney.	2 yrs
Due to Teratoma of testicle.	?
Due to Degenerative changes since birth.	
Other conditions See over	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Removal of testicle 7th 1946 - Teratoma.
Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Upton D Thomas M.D. M. D. or other

Address Dawsonville Md R.D. Boyds. Date signed Sept 23/47

This boy had birth palsy and was mentally deficient and had never walked or been able to ambulate.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08136

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney 7th

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Montgomery County General Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville RT #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: HENRY KELLY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	NEGRO	Married

6.(b) Name of husband or wife: Annie Kelly

6.(c) If alive, give age: March 26 81 years

7. Birth date of deceased (mo., day, yr.): March 26 1866

8. AGE:

Years	Months	Days	If less than one day
81	5	12	....hrs. ....min.

9. Birthplace: Montgomery Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: 0

FATHER

12. Name: CHARLES KELLY

13. Birthplace: ? Maryland

MOTHER

14. Maiden name: Elizabeth JOHNSON

15. Birthplace: ? Maryland

16. Informant: Annie Kelly

Address: Rockville RT #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1947 (month) (day) (year)

Cemetery or crematory: Sharp Street Church Cem.

Location: Sandy Spring Md.

18. Funeral director: Robert L. Snowden

Address: Rockville, Maryland

19. 9-10-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1947 at 12 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1947 to September 7 1947

and that I last saw h...alive on September 7, 1947

Immediate cause of death	DURATION
Cardiac Insufficiency	30+ days
Due to: Arteriosclerotic Heart Disease	? Years
Due to:	
Other conditions: Pulmonary Fibrosis + Emphysema; Benign prostatic hypertrophy; Treated Syphilis - Latent	? Years ? months

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas A Tumbleson M. D. or other

Address: Sandy Spring Md Date signed: 9/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

08137

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney (If outside city or town limits, write RURAL and give nearest town) Maryland

How long in above place of death? 15 MIN

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Lane

How long in hospital or institution? 15 MIN

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. Layhill (If rural, give LOCATION)

2.(a) If veteran, name war NONE

3.(a) FULL NAME INFANT GIRL Knight

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife None

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) September 14, 1947

8. AGE: Years — Months — Days — If less than one day — hrs. 15 min.

9. Birthplace Olney, Montgomery Co., Maryland. (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Aubrey Brook Burriss

13. Birthplace Layhill, Md.

MOTHER 14. Maiden name Lucille Anna Knight.

15. Birthplace Layhill, Md.

16. Informant Hospital records.

Address OLney - Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)

Cemetery or crematory Layhill Church Cemetery

Location Layhill, Md.

18. Funeral director Wm. Lawson Rumpfrey

Address Bethesda, Md.

19. Sept 14, 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1947, at 8:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/14 1947, to 9/14 1947

and that I last saw her alive on 9/14 1947

Immediate cause of death	DURATION
Atelectasis	
Due to Generilized Hydrops foetalis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Generalized Hydrops foetalis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard A. Yates M. D. M. D. or other

Address RFD #3 Rockville Md Date signed 9/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d X

08138

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MONTGOMERY

City or town near Clovenly, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town near Clovenly
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rockville Md. R # 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JAMES Albert King

3.(b) Social Security Number 578-07-3718

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Married

6.(b) Name of husband or wife Bessie Priebe King

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) August 9 1892

8. AGE: Years	Months	Days	If less than one day
55	1	14	hrs. min.

9. Birthplace District of Columbia
(Town, county, and state)

10. Usual occupation Auto Mechanic

11. Industry or business

FATHER 12. Name William E. King

13. Birthplace District of Columbia

MOTHER 14. Maiden name Annie Crump

15. Birthplace

16. Informant MRS. J. D. KING

Address Rockville, Md. R. #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26, 1947 (month) (day) (year)

Cemetery or crematory Sligo

Location Forest Glen md

18. Funeral director Roy W. Barber

Address Colesville md

19. Sept 25- 1947 (Date rec'd by registrar) Gertrude B. Fawley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1947, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 1947, to Sept 23 1947

and that I last saw him alive on Sept. 23 1947

Immediate cause of death PRIMARY Carcinoma of the lungs

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

DURATION
from
March 1, '47

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E. Tumbleson M. D. or other

Address Sandy Spring Md Date signed 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 D 08139

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one and a half days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? one and one half days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Cedar Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

KOESTER, Thomas Paul

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 September 1947

8. AGE: Years	Months	Days	If less than one day
		1½	hrs. min.

9. Birthplace: Bethesda, Montgomery, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Archibald I. Koester
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Hilda Mae Plantz
15. Birthplace: West Virginia

16. Informant: Father: Mr. Archibald I. Koester
Address: 605 Cedar La, Falls Church, Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof 9 25 47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers R.M.W.

Address: 3072 M St., NW, Washington, D. C.

19. 9-24 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 September 1947 19 at 6:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-21- 19 47 to 9-23-47 19 and that I last saw h im alive on 9-23-47 19

	DURATION
Immediate cause of death: Prematurity	12 hs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Confirmed the above cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: PAUL PETERSON, CAPT MC USN
M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/27/47

08140

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH:

County Montgomery

City or town 1216 Woodside Pkwy. Silver Spring Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1216 Woodside Pkwy.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank B. League

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 25 1877

8. AGE: Years 70 | Months 7 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Maryland (Town, county, and state)

10. Usual occupation machinist

11. Industry or business navy yard

FATHER 12. Name James B League

FATHER 13. Birthplace md

MOTHER 14. Maiden name Hanna Brown

MOTHER 15. Birthplace md

16. Informant Margery Stigler

Address 1216 Woodside Pkwy Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Maryland

18. Funeral director Robert A Mattingly

Address 1311 H St N E Wash DC

19. Sept 17 1947 (Date rec'd by registrar) Josephine M Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 19 47, at 2:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

	DURATION
Immediate cause of death	
Coronary occlusion	dur 5 min suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Sept 17 1947 M. D. or other

Address Gaithersburg Md Date signed 9-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

08141

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. Anchorage Tea Room

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edgar L. Levesque

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Levesque

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) December 29, 1903

8. AGE:	Years	Months	Days	If less than one day
	43	8	7	....hrs. ....min.

9. Birthplace Brooklyn New York (Town, county, and state)

10. Usual occupation Owner of Tea Room

11. Industry or business Restaurateur

FATHER 12. Name JOSEPH LEVESQUE

13. Birthplace ,Canada

MOTHER 14. Maiden name LEILA MANNY

15. Birthplace NEW YORK, NEW YORK

16. Informant Margaret Levesque

Address The Anchorage, Sandy Spring, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept 7, 1947 (month) (day) (year)

Cemetery or crematory Troy N.Y.

Location Troy N.Y.

18. Funeral director W. W. Chambers Co.

Address Riverdale, Md.

19. Sept 6 1947 Gertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1947 at 4:21 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h... alive on ....19....

	DURATION
Immediate cause of death Shock due to hemorrhage from Oesophageal Varices	8 hrs.
Due to Cirrhosis of Liver	? yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ....Date of op....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchart M.D. M. D. or other

Address Gaithersburg, Md Date signed 9/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 ex

08142

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos. 14 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 5 mos 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1916 Calvert Street, Northwest
(If rural, give LOCATION)
2.(a) If veteran, name wer: WW I

3.(a) FULL NAME
LOAN Roy William

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Viola Loan
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 18 December 1897

8. AGE: Years	Months	Days	If less than one day
49	8	30	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Information Clerk
11. Industry or business: Union Terminal, Wash., D. C.

FATHER
12. Name: Thomas Loan
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Allen
15. Birthplace: Virginia, deceased

16. Informant: Wife: Mrs. Viola Loan
Address: 1916 Calvert St., NW, Washington, D.C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 19 47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers
Address: 1400 Chapin Street, NW, Wash., D. C.

19. 9-17 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 September 19 47 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-3- 19 47 to 9-17- 19 47 and that I last saw him alive on 9-17- 19 47

	DURATION
Immediate cause of death: Angiosarcoma with metastatic lesion in the lung	
Due to: Original lesion in left pelvis.	
Due to:	
Other conditions: Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations: Exploratory ops. pelvic lesion - angiosarcoma. Date of op. 15 May
Autopsy results: Angiosarcoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

H B Eisberg
23. SIGNATURE: H. B. EISBERG, CDR MC USN M. D. or other
Address: USNH, Bethesda, Md. Date signed: 9-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08143

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery.
City or town: Rockville.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 226 East middle lane.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sadie Lyons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	widow

6.(b) Name of husband or wife: James Lyons
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1891

8. AGE: Years	Months	Days	If less than one day
56	7	8	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business:

FATHER
12. Name: Promise Williams
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Louise --
15. Birthplace: Virginia.

16. Informant: CHarles Walker, son
Address: 226 E Middle Lane, Rockville.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 1947 (month) (day) (year)
Cemetery or crematory: Mount Lat.
Location: Scotland, Maryland
18. Funeral director: R. L. Snowden
Address: 246 N. Wash. St. Rockville, Md.
19. Sept. 25 1947 (Date rec'd by registrar) Mrs E P Thompson per L. S. Buckels Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 19 47, at 5.10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 19 47, to Sept 22 19 47
and that I last saw her alive on Sept 21, 1947 19

Immediate cause of death	DURATION
Cerebral hemmorhage.	1w
Due to: Hypertension	5 y
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walker Walker M. D. or other
Address: Rockville, Md. Date signed 9-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08144

2/694

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos 28 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 3 mos 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Charlesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Shamrock Road
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I & II

3.(a) FULL NAME: MC GUIGAN John Stephen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Nantibess McGuigan
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 26 December 1885

8. AGE: Years	Months	Days	If less than one day
61	8	21	hrs. min.

9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: U. S. Marine Corps Retired
11. Industry or business

FATHER
12. Name: Bethe McGuigan
13. Birthplace: Ireland, deceased

MOTHER
14. Maiden name: Mary Appleby
15. Birthplace: Ireland, deceased

16. Informant: Wife; Mrs. Nantibess McGuigan
Address: 111 Shamrock Rd., Charlesville, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 18 (day) 47 (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: Timothy Hanlon Funeral Home R.P.G.
Address: 641 H St., NE, Wash., D. C.

19. 9-16- 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 September 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-19- 1947 to 9-16- 1947 and that I last saw him alive on 9-16- 1947

Immediate cause of death	DURATION
Metastatic adenocarcinoma	9 mos.
Due to: adenocarcinoma, rectum	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. L. McLaughlin M. D. or other
Address: U.S. Navy Hosp, Bethesda Date signed: 9-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/2014

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

08145

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist. of Col. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 731 Fern Place N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Miller Mr Elmer E

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ALLA miller

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): March 22, 1863

8. AGE: Years	Months	Days	If less than one day
84	6	6	hrs. min.

9. Birthplace: Jonesville, Indiana (Town, county, and state)

10. Usual occupation: Government Worker Retired

11. Industry or business:

FATHER — 12. Name: Mr John J Miller

13. Birthplace: Knox County, Ohio

MOTHER — 14. Maiden name: Elmina Critchfield

15. Birthplace: Knox County, Ohio

16. Informant: Washington Sanitarium & Hospital Records

Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1947. (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington D.C.

18. Funeral director: Arthur Walters

Address: 254 Carroll St. N.W. Takoma Park D.C.

19. Sept. 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/28 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/19 1933 to 9/28/1947 and that I last saw h[illegible] alive on 9/26/1947.

Immediate cause of death	DURATION
Acute Uremia	3 days.
Due to: Gen Arteriosclerosis	
Due to: Chronic Nephritis	

Other conditions: three days before death kidneys just stopped secreting, continue till death. Probable gen. arteriosclerosis is chief condition for cause of death.)

(Include pregnancy within 3 months of death)

10/5/47 a.s.

Major findings of operation: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard Y Snowden M. D. or other

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08146

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Damascus Rural R-F-D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Damascus Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lewis W Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Nellie Miller
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 16 - 1878

8. AGE: Years	Months	Days	If less than one day
69	2	21	hrs. min.

9. Birthplace: Bedford Co Pa (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Poultry Farm
FATHER 12. Name: John H Miller
FATHER 13. Birthplace: Bedford Pa
MOTHER 14. Maiden name: Elizabeth May miller
MOTHER 15. Birthplace: Bedford Pa
16. Informant: Mrs Nellie Logue Miller
Address: Damascus Md
17. Burial, cremation, or removal. Which? Burial Date thereof: Sept 8 1947 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Englesmith Pa Bedford Co
18. Funeral director: Roy W Barker
Address: Catonsville Md
19. Sept 6 1947 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1947 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 5 1947 to September 5 1947 and that I last saw him/her alive on September 5 1947

	DURATION
Immediate cause of death: Coronary occlusion	4 hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other
Address: Damascus, Md. Date signed: 9/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08147

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Usual~~ street address where death occurred: 8515 Cedar St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8515 Cedar St.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: FRANK LEE MORTIMER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Catherine J.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 16th. 1865

8. AGE: Years	Months	Days	If less than one day
81	9	14	..... hrs. ..... min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: John T. Mortimer

13. Birthplace: Wash. D. C.

MOTHER — 14. Maiden name: Deborah Bennett

15. Birthplace: Wash. D. C.

16. Informant: Mrs. Ernest S. Price

Address: 8515 Cedar St. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/47 (month) (day) (year)

Cemetery or crematory: Hyattstown Meth't Church

Location: Hyattstown, Montg. Co. Md.

18. Funeral director: Harry W. Dempsey

Address: Silver Spring, Md.

19. Sept 29 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 19 47, at 6:04 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 19 47, to Sept. 28 19 47

and that I last saw h.. alive on Sept 27 19 47

	DURATION
Immediate cause of death: Terminal Bronchial Pneumonia	2 days
Due to: Arteriosclerotic Heart Disease & decompensation	3 yrs -
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Francis L. Rieland M.D. M. D. or other

Address: 777 Columbia Ave N. W. Date signed: 9/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(552 - N.H.)
Dr. Dr. Harding

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 08148

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ Days
Hospital, institution, or street address where death occurred: Washington San. + Hospital
How long in hospital or institution? 2½ Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 819 Islington Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. BERTHA NEELY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles H. Neely
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 1, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	25	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Elisha Taylor
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Clevenger
15. Birthplace: Penna.

16. Informant: Hospital Records.
Address: Washington, Sanitarium

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill Cemetery
Location: Alexandria, Va.
18. Funeral director: S. N. Hines Co.
Address: 2901 14th St., N.W. D.C.
19. Sept-25 1947 (Date rec'd by registrar) J. Elton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1947, at 3-10 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about July 1947 to Sept 25 1947
and that I last saw h.a.n. alive on Sept 25 1947

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive Cardiovascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dean Z. Harding M.D. (M. D. or other)
Address: 113 Carroll St NW Wash D.C. Date signed: 9-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 507

08149

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1314 North Harrison Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: NIEKUM, Marian Emma

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Capt. Phil Niekum USN

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12-13-03

8. AGE: Years	Months	Days	If less than one day
43	8	18	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Cooke,
13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Emma Cooke
15. Birthplace: Pennsylvania

16. Informant: Husband: Capt. Phil Niekum USN
Address: 1314 N. Harrison St., Arlington, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 - 4 - 47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Ives Funeral Home

Address: 2847 Wilson Blvd., Arlington, Va.

19. 9-4 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 September 19 47 at 4:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1- 19 47 to 9-1- 19 47 and that I last saw h...er alive on 9-1- 19 47

Immediate cause of death	DURATION
Metastatic carcinoma	1 yr.
Due to: Cystic carcinoma, breast.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Wm. V. MacMurtrie Jr.

23. SIGNATURE: W. J. MAC MURTRIE, LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed 9-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08150

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 9505 Baltimore Drive

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James J. Nolan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Julia D Nolan

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7 1873

8. AGE:

Years	Months	Days	If less than one day
73	11		hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Bricklayer

FATHER
12. Name James Nolan
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Mannix
15. Birthplace Ireland

16. Informant Victor L. Nolan

Address 9505 - Biltmore Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 13 1947 (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Washington D.C.

18. Funeral director Frank Geiers Sons Co

Address 3605-14 St NW Wash. DC

19. Sept 11 (Date rec'd by registrar) 19 47 Josephine Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 19 47, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 19 46, to 9/10 19 47, and that I last saw h[illegible] alive on 9/9 19 47.

	DURATION
Immediate cause of death: Cerebral hemorrhage,	4 days
Due to: hypertension &	
Due to: arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. W. Nealon Jr. M.D.
M.D. or other

Address 1746 K St NW Date signed 9/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Nealon
1746-K

08151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 88 Darrington Street, Southwest
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PANTEL, Marguerite R.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Mr. Herman F. Pantel
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 4 March 1895

8. AGE:	Years	Months	Days	If less than one day
	52	6	2	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: A. Randolph
13. Birthplace: Penna., deceased

MOTHER
14. Maiden name: Rebecca Bunnigan
15. Birthplace: Penna., deceased

16. Informant: Husb: Mr. Herman F. Pantel
Address: 88 Darrington St, SW, Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 9 (day) 47 (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St., SE, Wash., D. C.

19. 9-6-47 (Date rec'd by registrar) 19... Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 September 1947, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-7- 1947 to 9-6- 1947 and that I last saw h...er alive on 9-6- 1947

	DURATION
Immediate cause of death: Hepatitis, chronic	8 mo.
Due to: ↗ Cholangitis	8 mo.
Due to: Partial common duct obstruction ↗	8 mo.
Due to:	
Other conditions: Bronchopneumonia and pulmonary edema and Gastric ulcer (Include pregnancy within 3 months of death)	

Major findings of operations: Gastric ulcer, abdominal adhesions and biliary obstruction & hepatitis Date of op. 8/27/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. C. Owens
J. C. OWENS, LCDR MC USN M. D. or other
Address: USNH., Bethesda, Md. Date signed: 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. See that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08152

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 829 Decatur Street, Northwest
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: PASOUR, William Lloyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Bertha M. Pasour
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): 11 May 1888

8. AGE: Years	Months	Days	If less than one day
59	4	0	....hrs. ....min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Retired Policeman
11. Industry or business: District of Columbia Police

FATHER
12. Name: John Pasour
13. Birthplace: North Carolina, deceased

MOTHER
14. Maiden name: Margaret ———
15. Birthplace: North Carolina, deceased

16. Informant: Wife: Mrs. Bertha M. Pasour
Address: 829 Decatur St., NW, Wash., D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 15 (day) 47 (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: Deal Funeral Home
Address: 4812 Georgia Ave., NW, Wash., D. C.

19. 9-11- 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 September 1947, at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-27- 1947, to 9-11- 1947 and that I last saw him alive on 9-11- 1947

Immediate cause of death	DURATION
Hemorrhage Cerebral	2 hours
Due to: Hypertension; Arteriosclerosis	known 6 weeks
Due to: Diabetes Mellitus	unknown
Other conditions: Central Nervous System Syphilis	7 years

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

24. SIGNATURE: W. A. DINSMORE, LCDR MC USN (M. D. or other)
Address: USNH, Bethesda, Maryland Date signed: 9-11-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08153

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lillian B. Pattie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. O M. Pattie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1893

8. AGE: Years 54 | Months 0 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Rockbridge Co. Va
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Joseph Barger

13. Birthplace Virginia

MOTHER 14. Maiden name Ellen Ford

15. Birthplace Virginia

16. Informant Mr. O. M. Pattie

Address Sandy Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1947 (month) (day) (year)

Cemetery or crematory Burtonsville Union

Location Burtonsville, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Sept 3, 1947 (Date rec'd by registrar) Gertrude K. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1947, at 7:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to Sept. 1, 1947

and that I last saw her alive on Sept. 1, 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 hours
Due to: Hypertension	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Chas. E. Tumblason M. D. or other

Address Sandy Spring, Md. Date signed 9-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 E

08154

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos 25 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 3 mos 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County:
City or town: Smyrna
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 40 South Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I & II ✓

3.(a) FULL NAME: PENN, Albert Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Helen Smith Penn
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): 11 September 1885

8. AGE:	Years	Months	Days	If less than one day
	62	0	8	....hrs. ....min.

9. Birthplace: Texas (Town, county, and atate)
10. Usual occupation: Retired
11. Industry or business: U. S. Navy
FATHER 12. Name: James Saunders Penn
13. Birthplace: Virginia, deceased
MOTHER 14. Maiden name: Virginia J. Miller
15. Birthplace: Virginia, deceased
16. Informant: Wife: Mrs. Helen Penn
Address: 40 S. Main S., Smyrna, Delaware
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 23 (day) 47 (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: Wm. Reuben Pumphrey C.F.V.
Address: 7557 Wisconsin Ave., Bethesda, Md.
19. 9-20 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 September 19 47 at 2:10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-25- 19 47 to 9-19- 19 47
and that I last saw h im alive on 9-19- 19 47

	DURATION
Immediate cause of death: Terminal Bronchopneumonia	2 days
Due to: Cerebral Hemorrhage	3 days
Due to: Carcinoma of Prostate with extensive metastasis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: Injured at work?

23. SIGNATURE: H. J. COKELY, CAPT MC USN M. D. or other
Address: USNH, Bethesda, Md. Date signed: 9-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08155

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Takoma Park 12, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital Takoma Park, MD

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges Co.

City or town: Hyattsville, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5709 - 43rd St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Frank Peterson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mildred M. Peterson

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): January 3, 1890

8. AGE:

Years	Months	Days	If less than one day
57	8	11	...hrs. ...min.

9. Birthplace: Silver Lake, Wisconsin
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: U. S. Navy

FATHER
12. Name: Nels Peterson
13. Birthplace: Den mark

MOTHER
14. Maiden name: Elsie Jorgansen
15. Birthplace: Den mark

16. Informant: Mrs. Theo Machen Peterson
Address: 5709 - 43rd St. Hyattsville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 16 1947 (month) (day) (year)

Cemetery or crematory:

Location: Hyattsville, Md.

18. Funeral director: J. Donald's Sons.

Address: Hyattsville Md

19. Sept 16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/16 19 47 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/2 19 47 to 9/16 19 47 and that I last saw h. 3 49 p.m. alive on 9/16 19 47

Immediate cause of death	DURATION
Acute pancreatitis	5 days
Due to	
Due to	
Other conditions: Postoperative gastro enterostomy and enteroenterostomy (Include pregnancy within 3 months of death)	13 days. 2 days.

Major findings of operations: Duodenal stricture due to old ulcers and scars. Date of op. 9/3/47, 9/14/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bruce Benjamin, M.D. M. D. or other

Address: Bethesda, Md. Date signed 9/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08156

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
8511 Cedar St.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8511 Cedar St.
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Mary L Pratt

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	widowed

6.(b) Name of husband or wife Charles Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 29th. 1878

8. AGE: Years	Months	Days	If less than one day
68	11	4	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Samuel Turner
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Leizear
15. Birthplace Maryland

16. Informant Mrs. L. B. Mason

Address 8511 Cedar St.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/6/1947 (month) (day) (year)

Cemetery or crematory George Washington Memorial

Location Riggs Rd. Extended

16. Funeral director W. Conrad E. Pumphrey

Address Silver Spring - Maryland

19. Sept 5 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1947 at 10:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Sept 3 1947 and that I last saw her alive on Sept 3 1947

	DURATION
Immediate cause of death myocarditis	4 months
Due to Hypertension	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

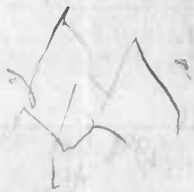
23. SIGNATURE John N. Andrews M.D. M. D. or other

Address Silver Spring Md Date signed Sept 3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08157

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Everett Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I & II

3.(a) FULL NAME: PRIOR, Wallace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowered

6.(b) Name of husband or wife: widowered

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 27 November 1892

8. AGE: Years	Months	Days	If less than one day
54	9	9	..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U. S. Navy

FATHER
12. Name: Warren S. Prior
13. Birthplace: North Carolina, deceased

MOTHER
14. Maiden name: Lena McGee
15. Birthplace: North Carolina, deceased

16. Informant: Niece: Mrs. Robert Berry
Address: 113 Everett St., Kensington, Md.

17. removal (Burial, cremation, or removal, Which?) Date thereof 9 (month) 5 (day) 47 (year)

Cemetery or crematory: Silver Brook Cemetery

Location: Anderson, South Carolina

18. Funeral director: Wm. Reuben Pumphrey C.A.V.

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 9-5-47 (Date rec'd by registrar) 19 Mary Charlotte Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 September 19 47 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-4- 1947 to 9-5- 1947 and that I last saw h im alive on 9-5- 1947

Immediate cause of death	DURATION
Coronary Thrombosis with myocardial infarction	10 hours
Due to: Coronary arteriosclerosis	2 years
Due to: Generalized arteriosclerosis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE T. E. Jarrett T. E. JARRETT, CDR MC USN (M. D. or other)

Address: USNH., Bethesda, Md. Date signed: 9-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

9/9/47

08158

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.: rural
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: PROCTOR Roger St.George

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife: Edith Proctor
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 23 April 1894

8. AGE:

Years	Months	Days	If less than one day
53	4	25	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Railroad Foreman
11. Industry or business: Baltimore and Ohio Railroad

FATHER
12. Name: Augustus Proctor
13. Birthplace: Maryland, deceased

MOTHER
14. Maiden name: Georgana Larry
15. Birthplace: Maryland, deceased

16. Informant: Wife: Mrs. Edith Proctor
Address: Point of Rocks, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof .... (month) (day) (year)
Cemetery or crematory: Colored Cemetery
Location: Point of Rocks, Maryland

18. Funeral director: M. R. Etchison Funeral Home
Address: 106 East Church St., Frederick, Md.

19. 9-17 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 September 19 47 at 10:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-18- 19 47 to 9-17- 19 47 and that I last saw him alive on 9-17- 19 47

Immediate cause of death	DURATION
Bronchogenic Carcinoma	1 yr ?
Due to	
Due to	
Other conditions: Terminal Pulmonary Edema	

(Include pregnancy within 3 months of death)

Major findings of operations: Diffuse carcinomatosis of rt. pleural cavity and rt. lung Date of op. 9-16-47
Autopsy results: not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Kenneth L. Hardy, M.D.
23. SIGNATURE: KENNETH L. HARDY, LTJG MCR USNR
Address: USNH, Bethesda, Md. M. D. or other
Date signed: 9-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08159

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hosp.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 724 Chesapeake Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Beatrice Rolando

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Mr. Isilio Rolando

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): AUG-17-1877

8. AGE: Years	Months	Days	If less than one day
70	—	29	..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Claude Pilotti
13. Birthplace: Italy

MOTHER
14. Maiden name: Anna Ste Sanacci
15. Birthplace: Italy

16. Informant: Medical records

Address: Washington Sanitarium + Hosp.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-18-1947 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Aliquippa, Beaver Co. Penna.

18. Funeral director: Warner & Pemphrey

Address: Silver Spring, Md.

19. Sept 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1947 to Sept 16 1947 and that I last saw h.e.r alive on September 16 1947

Immediate cause of death	DURATION
Extensive myocardial infarction	
Due to: Coronary arteriosclerosis	
Due to:	
Other conditions: Recent congestive heart failure and bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles E. Law M. D. or other

Address: 1801 K St. N.W., Wash. D.C. Date signed: 9-16-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08160

157e

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mths

Hospital, institution, or street address where death occurred:

10031 Brunnett Avenue,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10031 Brunnett Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME FRANCIS PAUL ROTHENBERG

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1947

8. AGE:

Years	Months	Days	If less than one day
0	2	11	hrs. min.

9. Birthplace Bethesda, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name James Frederick Rothenberg

13. Birthplace Annapolis, Md.

MOTHER

14. Maiden name Petronella Mendel

15. Birthplace Jasper, Indiana

16. Informant Mrs. Petronella M. Rothenberg

Address 10031 Brunnett Ave, Sil. Sp. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19, 1947 (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Forest Glen, Md.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. NW, Takoma Park, D.C.

19. Sept 19 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947 at 2:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1947 to September 17 1947 and that I last saw him alive on September 16 1947

Immediate cause of death	DURATION
Congenital Heart disease (Three chambered heart - one ventricle)	Since birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results Congenital heart disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Aaron H. Traum M. D. or other

Address 8237 Georgia Ave Silver Spring Md. Date signed Sept 18 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

8161

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: 10000 Georgia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 907 - Delaware Road N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: None ✓

3.(a) FULL NAME: Lily V. Speck

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. H. Speck

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 31 1870

8. AGE: Years	Months	Days	If less than one day
76	8	1	..... hrs. ..... min.

9. Birthplace: Philadelphia Penna (Town, county, and state)

10. Usual occupation: Dressmaker

11. Industry or business:

FATHER — 12. Name: Harry Boyd

13. Birthplace: Penna

MOTHER — 14. Maiden name: Harriet Bowers

15. Birthplace: Penna

16. Informant: Alexander T. Speck

Address: 124 South Central Ave Glendale Ariz.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Sept. 4. 1947 (month) (day) (year)

Cemetery or crematory: Lees Crematorium

Location: Washington, D. C.

18. Funeral director: J. William Lee Sons Co.

Address: 300 - 4th St. N.E.

19. Sept 3 1947 (Date rec'd by registrar) Joseph M. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1947 at 1205 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6 1940 to Sept 2 1947

and that I last saw h.. alive on Sept 1 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Cerebral arterio sclerosis	
Due to:	
Other conditions: terminal bronchial pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John V. Dolan 2nd M. D. or other

Address: 3500 Conn Ave Date signed Sept 3, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insert age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 X

CERTIFICATE OF DEATH

08162

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. Wheaton Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lynda Hicks Sturgis

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Russell Sturgis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	23	..... hrs. ..... min.

9. Birthplace New York State

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name William H. Hicks

13. Birthplace New York State

MOTHER

14. Maiden name Sarah Eliz. Cannon

15. Birthplace Unknown

16. Informant Mrs. Helen Sturgis Owen

Address Wheaton Road Kensington, Md.

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof 9/29/47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland

18. Funeral director Wm Reuben Humphrey

Address 7557 Wisconsin Ave., Bethesda, Md.

19. 9/27 1947 Mr E Jules

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1945, to Sept. 26 1947

and that I last saw h— alive on Sept. 26 1947

Immediate cause of death	DURATION
Metastatic Carcinomma	2 months
Due to Carcinoma of transverse Colon	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Transverse Colon Date of op. July 29, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Marion Bauschard M.D.

M. D. or other

Address 9401 Sutton place Silver Spring, Md. Date signed 9/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08163

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days 3 Hours
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 3 days 3 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2706 Emmet Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME David A. Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Margaret Taylor Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24 1866

8. AGE: Years	Months	Days	If less than one day
81	2	7	..... hrs. ..... min.

9. Birthplace Broadway Virginia (Town, county, and state)
10. Usual occupation Printer, retired 1937
11. Industry or business Gov. Printing Office
FATHER 12. Name Edwin Taylor
13. Birthplace Broadway Va.
MOTHER 14. Maiden name Mary Burkholder
15. Birthplace Penn.
16. Informant Taylor A. Taylor
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7 1947 (month) (day) (year)
Cemetery or crematory
Location Harrisonburg Va.
18. Funeral director Neal Funeral Home
Address 4812 Ga Ave N.W.
19. 9/3 1947 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3rd 1947 at 6 o'clock A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1/47 19.. to 9/3/47 19.. and that I last saw h.i.m alive on 9/1/47 19..

Immediate cause of death	Duration
Myocardial Degeneration	unk.
Due to Arteriosclerosis; generalized	unk.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NO Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Allen M.D. M. D. or other
Address Kensington Md. Date signed 9/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08164

507

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9910 Inverwood Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME KATHRYN EALY TAYLOR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: Henry J Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 28 - 1904

8. AGE: Years: 43 Months: 4 Days: 29 If less than one day: hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Elmer L. Ealy

13. Birthplace: Pa.

MOTHER — 14. Maiden name: AMELIA EALY

15. Birthplace: Pa.

16. Informant: Henry J Taylor

Address: 9910 Inverwood Lane

17. (Burial, cremation, or removal. Which?) Cremation Date thereof Sept 27 1947 (month) (day) (year)

Cemetery or crematory: Lee's crematory

Location: Washington D.C.

18. Funeral director: J Wm Rice Funeral Co.

Address: 300 4½ St. N.E.

19. Sept 27 1947 (Date rec'd by registrar) Josephine Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1947, to Sept. 27 1947 and that I last saw her alive on Sept. 27 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to: Carcinoma left breast	4 yrs
Due to: Carcinoma right breast	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Left breast removed 1943 Rt breast removed 1944 Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank G Jack M.D. M. D. or other

Address: 8248 Ga. Ave. Silver Spring, Md. Date signed: 9-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Lisron

I was called in to see
Mrs. Kathryn Taylor in
an emergency because
her physician Dr. Richard
B. Phillips was out of town

Frank G. Zack M.D.

08165

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

120 b

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9228 Woodland Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Lillian Beatrice Thomas.

3. (b) Social Security Number 218-20-0554

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr George Maxwell Thomas
9228 Woodland Ave. 6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb -14- 1901

8. AGE: Years	Months	Days	If less than one day
46	6	26	... hrs. ... min.

9. Birthplace District of Columbia
(Town, county, and state)

10. Usual occupation Clerical

11. Industry or business Johns Hopkins Research

FATHER 12. Name Douglas Spencer

13. Birthplace Maryland

MOTHER 14. Maiden name Regina Maria Walter

15. Birthplace Maryland

16. Informant Mr George M. Thomas

Address 9228 Woodland Dr Silver Springs Md

17. Burial Date thereof Sept- 12- 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery ~~or crematory~~ Arlington National

Location Arlington Co. Virginia

18. Funeral director Warner E. Pumphrey

Address Silver Spring- Md

19 Sept- 11- 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1947 at 3 15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/27/ 1947 to 9/10/ 1947

and that I last saw her alive on 9/9/ 1947

Immediate cause of death 129 Ulcerative colitis (fulminating?) with perforation & peritonitis — DURATION 6 wk 7 days

Due to

Due to

Other conditions

123

(Include pregnancy within 3 months of death)

Major findings of operations Perforated bowel, peritonitis 129; abnormal connection bet small & large bowel

Date of op. 9/2/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas M Hotchkin M D
M.D. or other

Address 511 Underwood St N W Date signed 9/10/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08166

CERTIFICATE OF DEATH

Reg. Diat. No. 206

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours 29 minutes
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 12 hours 29 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4617 West Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME John ~~INFANT~~ ~~BOY~~ VAN STADEN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 11, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	0	12 hrs. 29 min.

9. Birthplace Bethesda, Montg. Co., Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business None

FATHER
12. Name George A. VanStaden
13. Birthplace Equinank, Pa.

MOTHER
14. Maiden name Evelyn V. Hodnett
15. Birthplace Englewood, N. J.

16. Informant George A. VanStaden (father)
Address Bethesda 14, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1947 (month) (day) (year)
Cemetery or crematory St. Marys Catholic Cemetery
Location Rockville, Maryland

18. Funeral director Wm. Rawlings Trumpfheller
Address Bethesda 14, Maryland.

19. 9/12 (Date rec'd by registrar) 1947 M. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1947 at 3:00P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1947 to Sept. 11 1947 and that I last saw him alive on Sept. 11 1947

Immediate cause of death	DURATION
Prematurity - 27 weeks	-
Due to -	
Due to -	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. -
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. P. Smithson M. D.
M. D. or other
Address Rockville, Maryland Date signed 9/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08167

830

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural - Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6/17/47 -
Hospital, institution, or street address where death occurred:
Cedarcroft Sanitarium
How long in hospital or institution? 6/17/47 -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Herbert Springs, Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY (CRAPO) WAINWRIGHT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Leonard Wainwright
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 30, 1878 (?)

8. AGE: Years	Months	Days	If less than one day
68	10	9	hrs. min.

9. Birthplace: Waukegan, Illinois
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: ---- Crapo
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary (unknown)
15. Birthplace: "

18. Informant: Mrs. Richard Dyas
Address: Herbert Springs, Va.

17. Removal - Waukegan. See (Burial, cremation, or removal. Which?) Date thereof 9-10-47 (month) (day) (year)
Cemetery or crematory: Oakwood Cemetery
Location: Waukegan Ill.

18. Funeral director: Jas. J. Fowler's Sons
Address: 1754 Pa Ave N.W.

19. Sept 10 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1947, at 11:?? P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 - 1947 to Sept. 9 - 1947
and that I last saw h.. alive on Sept. 9 - 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Cerebral Arteriosclerosis	?
Due to:	
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard B. Thibadeau M.D. (or other)
Address: Cedarcroft Sanitarium Silver Spring Md. Date signed: 9/9-47.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08168

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ine correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Boyds, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Boyds, Maryland (If outside city or town limits, write RURAL and give nesreat town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME WATKINS, Mary Eliza

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frank W. Watkins deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 20, 1861

8. AGE: Years	Months	Days	If less than one day
86	0	4	..... hrs. ..... min.

9. Birthplace Montgomery County, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Curlight Green
13. Birthplace Montgomery County, Maryland

MOTHER 14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr. Robert Green
Address Boyds, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/47 (month) (day) (year)
Cemetery or crematory Rockville Union Cemetery
Location Rockville, Maryland

18. Funeral director W. Reuben Humphreys
Address 7557 Wisconsin Avenue, Bethesda, Md.

19. Sept. 27 19.47 (Date rec'd by registrar) Edna L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1946 to September 24 1947 and that I last saw h. E.R. alive on September 3 1947

Immediate cause of death Arterio Sclerotic cardio vascular disease — DURATION 15 years

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or other
Address Washington, D.C. Md. Date signed 9/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 200a

08169

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 55 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 5614 Glenwood Rd - (If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME William K. Watt

3.(b) Social Security Number None

4. Sex male
5. Color or race white
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Nettie E. Watt
6.(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) July 30, 1903.

8. AGE: Years 44 Months 1 Days 17 If less than one day ... hrs. ... min.

9. Birthplace Colfax, Iowa (Town, county, and state)
10. Usual occupation Office executive
11. Industry or business U. S. Govt.

FATHER
12. Name C. W. Watt
13. Birthplace Colfax, Iowa

MOTHER
14. Maiden name Nora Dales
15. Birthplace Colfax Iowa

16. Informant Nettie E. Watts (wife)
Address Same

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof Sept. 18, 1947 (month) (day) (year)
Cemetery or crematory Newton, Cemetery
Location Newton, Iowa

18. Funeral director Wm Reuben Pumphrey
Address Bethesda, Maryland

19. 9/17 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 16, 1947 at 4:03 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Sept - 1947 to 16 Sept. 1947
and that I last saw him alive on 16 Sept. 1947

	DURATION
Immediate cause of death Cardiac Failure -	one min.
Due to Hay Fever - toxic - cause not determined -	4 days.
Due to	
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results Gross findings negative -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John G. Bell M.D. M. D. or other
Address 7938 Georgetown Rd Beth. Md. Date signed 16 Sept 47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52 L X

08170

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 East Capitol Street
(If rurol, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: WEISS, Edward Alfred

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 April 1876

8. AGE: Years	Months	Days	If less than one day
71	5	8	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Conrad Weiss
13. Birthplace: Germany, deceased

MOTHER
14. Maiden name: Marie ?????
15. Birthplace: Germany, deceased

16. Informant: Neice; Mrs. Anna K. Beck
Address: 812 East Capitol St., Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1947 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Lee Funeral Home G. E. M.

Address: 4th & Mass, NE, Washington, D. C.

19. 9-26 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 September 1947 at 1:55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-5- 1947 to 9-25- 1947 and that I last saw h im alive on 9-25- 1947

	DURATION
Immediate cause of death: UREMIA	2 WKS
Due to: HYDRONEPHROSIS RIGHT AND PYONEPHROSIS LEFT	?
Due to: EXTENSIVE CARCINOMA OF URINARY BLADDER WITH MESTATASES TO REGINOAL NODES	?
Other conditions: FIBRINOUS PERICARDITIS ARTERTOSCLEROSIS (In 3 months of death)	?

Major findings of operations: NO OPERATIONS Date of op.

Autopsy results: CARCINOMA URINARY BLADDER

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. N. Quilter T. N. QUILTER, LTJG MC USN
M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

9/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08171

Reg. Diat. No. 216

M

Correct age

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 minutes

Hospital, Institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd. - Bethesda Md

How long in hospital or Institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 486 F St. S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war None ✓

3.(a) FULL NAME Charles C. Weitzel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Male	W	

6.(b) Name of husband or wife Mrs Lois Weitzel

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1907

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39 39	10			

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business Fireman

FATHER 12. Name Charles C Weitzel

FATHER 13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Grace Hopkins

MOTHER 15. Birthplace Washington, D.C.

18. Informant Mrs Lois Weitzel

Address 486 F St S.W. Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/17/47 (month) (day) (year)

Cemetery or crematory Prospect Hill

Location Washington D.C.

18. Funeral director Robt A. Mattingly

Address 131 11th St. S.E. Wash. D.C.

19. 9/17 (Date rec'd by registrar) 19 47 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 19 47 at 9 00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Francis J Brockett md M. D. or other

Address Gaithersburg md Date signed 9-17-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08172

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 460 L Street, Southwest
(If rural, give LOCATION)

2.(a) If veteran, name war WW I ✓

3.(a) FULL NAME WHYTE, Raymond (nmi)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 May 1895

8. AGE: Years 52 | Months 4 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Laborer

FATHER
12. Name Charles Whyte
13. Birthplace Washington, D. C., deceased

MOTHER
14. Maiden name Emma Marshal
15. Birthplace Washington, D. C., deceased

16. Informant Aunt: Mrs. Susie B. Harris
Address 460 L St., SW, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 2 (day) 47 (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director Barnes and Matthews
Address 614 4th St., SW, Washington, D. C.

19. 9-27 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 September 19 47, at 2:51 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15- 19 47 to 9-27- 19 47 and that I last saw h im alive on 9-27- 19 47

Immediate cause of death	DURATION
CORONARY THROMBOSIS with Myocardial Infarction	2 WEEKS
Due to CORONARY ARTERIOSCLEROSIS	
Due to	
Other conditions ARTERIOLONEPHROSCLEROSIS; CONGESTIVE HEART FAILURE	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results NOT GRANTED BY NEXT OF KIN

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE J. B. Bryan J. B. BRYAN, LTJG MC USNR
M. D. or other

Address USNH, Bethesda, Maryland Date signed 9-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47cK

08173

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 18 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 1 mo, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 903 M Street, Northwest

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: WILKINS, William (nmi)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife: Mrs. Almira Wilkins

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 12 June 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	2	12		

8. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Clarendon Cafe, Clarendon, Va.

FATHER — 12. Name: James Wilkins

FATHER — 13. Birthplace: North Carolina, deceased

MOTHER — 14. Maiden name: Ginnie Smith

MOTHER — 15. Birthplace: North Carolina

16. Informant: Wife: Mrs. Almira Wilkins

Address: 903 M St., NW, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 30 47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. Ernest Jarvis J.W.H.

Address: 1432 U St., NW, Washington, D. C.

19. 9-24 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 September 19 47 at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6- 19 47, to 9-24- 19 47 and that I last saw him alive on 9-24- 19 47

Immediate cause of death: Carcinoma, Rt Bronchus Ind.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C.H.C.SMITH, CDR MC USN

M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08174

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1307 Lindton Court, Northeast
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

WILLIAMS, Ernest (rural)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 November 1899

8. AGE: Years	Months	Days	If less than one day
47	10	17	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: John Williams
13. Birthplace: unknown, deceased

MOTHER
14. Maiden name: Rose Pinkington
15. Birthplace: unknown, deceased

16. Informant: Friend: Mrs. Emma Ashton
Address: 1307 Lindton Ct., NE, Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9 24 47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Nelson E. Bush E.T.M.

Address: 1357 H St., NE, Washington, D. C.

19. 9-22 (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 September 19 47 at 12:10 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-12- 19 47 to 9-21- 19 47 and that I last saw him alive on 9-21- 19 47

Immediate cause of death	DURATION
Diffuse miliary tuberculosis involving heart, lungs, spleen, kidneys & mediastinal nodes.	1 yr?
Due to:	
Due to:	
Other conditions: Thrombosis left popliteal vein	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: S F Kaufman
S.F.KAUFMAN, LTJG MCR USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 9-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

7/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92a

08175

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 Warner Street, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: YOUNG, Fred (nmi)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Hilda P. Young

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 7 May 1896

8. AGE: Years	Months	Days	If less than one day
51	4	22	....hrs. ....min.

9. Birthplace: Maine (Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business: Civil Service

FATHER
12. Name: Fred Young
13. Birthplace: Maine

MOTHER
14. Maiden name: Ruth Willis
15. Birthplace: Massachusetts

16. Informant: Wife: Mrs. Hilda P. Young
Address: 416 Warner St., NW, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10 (month) 3 (day) 47 (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Takoma Funeral Home D.C.
Address: 254 Carroll St., NW, Washington, D. C.

19. 9-30 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 September 19 47 at 3:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-27- 19 47 to 9-29- 19 47 and that I last saw h im alive on 9-29- 19 47

Immediate cause of death	DURATION
aortic Regurgitation with congestive Heart Failure	6 mo. I
Due to: Hypertension (clinical)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. C. Stevens Jr. H. L. C. STEVENS, JR., LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Maryland Date signed: 9-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 ft

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Mont.
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ZOLLINHOFER, Elizabeth Susan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 December 1876

8. AGE: Years	Months	Days	If less than one day
70	9	13	hrs. min.

8. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Lorenzo B. Gough
13. Birthplace: Maryland, deceased

MOTHER
14. Maiden name: Mary A. Dill
15. Birthplace: Penna., deceased

16. Informant: Daughter: Mrs. Rosa Bond
Address: Olney, Maryland

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 20 (day) 47 (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Cedar Hill, Maryland
18. Funeral director: W. W. Chambers Co. H.H.
Address: 517 11th St., SE, Washington, D. C.
19. 9-19 (Date rec'd by registrar) 19 47 Geary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 September 19 47 at 10:22 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-27- 19 47 to 9-18- 19 47 and that I last saw h er alive on 9-18- 19 47

Immediate cause of death	DURATION
Carcinoma of Hepatic Ducts with biliary obstruction.	3 mos.
Due to	
Due to	

Other conditions ① Uremia ② Hepato renal syndrome ③ Cholangitis ④ Biliary cirrhosis.
(Include pregnancy within 3 months of death)
Major findings of operations Adenocarcinoma of Hepatic Ducts Date of op. 9/10/47
Autopsy results ① Adenocarcinoma of Bile Ducts ② Uremia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. C. Owens, LCDR MC USN M. D. or other
Address: USNH, Bethesda, Md. Date signed 9-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/24/47